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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JAMIE MARIE DVORAK** **30 Horizon Avenue Apt. 6** **Los Angeles, CA 90291** **Registered Nurse License No. 708763** Respondent.	Case No. 2011-653 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board").

2. On or about July 27, 2007, the Board issued Registered Nurse License Number 708763 to Jamie Marie Dvorak (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2012, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Code section 2761 provides, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse … for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

…

7. Code section 2762 provides, in pertinent part:

"In addition to other acts constituting unprofessional conduct … it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of the law, or prescribe, or except as directed by a licensed physician … any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug … as defined in Section 4022.

…

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

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REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

10. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY PROVISION

11. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUG DEFINITIONS

12. Hydromorphone, trade name Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code Section 11055(b)(1)(k) and a dangerous drug per Business and Professions Code Section 4022. Dilaudid is a trade name for Hydromorphone.

13. Oxycodone, trade name Oxycontin, is a Schedule II controlled substance pursuant to Health and Safety Code Section 11055(b)(1)(N) and a dangerous drug per Business and Professions Code Section 4022.

14. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code Section 11055(b)(1)(M) and a dangerous drug per Business and Professions Code Section 4022.

15. Lorazepam, trade name Ativan, is a Schedule IV controlled substance pursuant to Health and Safety Code Section 11057(d)(16) and a dangerous drug per Business and Professions

Code Section 4022.

16. Zolpidem, trade name Ambien, is a Schedule IV controlled substance pursuant to Health and Safety Code Section 11057(d)(32) and a dangerous drug per Business and Professions Code Section 4022.

BACKGROUND FACTS

Centinela Hospital Medical Center

17. Respondent was employed as a registered nurse for Centinela Hospital Medical Center ("CHMC") during time period between 2/11/08 to 9/5/08. At all times relevant to the charges herein, CHMC used a drug dispensing system called the Pyxis System [1]. On or around 9/8/08, Respondent was terminated after an investigation and review of Respondent's conduct with respect to seven (7) patients' medical records, doctor's orders, Pyxis activity reports, medication administration records ("MAR") and nursing notes revealed that she made "obvious" medication discrepancies in documentation and practiced outside the scope of her license by giving medication to patients without physician orders, as set forth below. CHMC reported the Respondent as "Do Not Return" to her nursing registry after the discoveries were made.

PATIENT 1 (MR - V00860012036)

Date	Physician Orders	Medication Administration Record	Pyxis Record (Removal)
8/19/08	No physician order for Dilaudid	No documentation that Dilaudid was given	8:07 p.m.: *4mg Dilaudid*

SUMMARY: Respondent obtained 4mg Dilaudid for this patient without a physician's order for Dilaudid. Respondent also failed to document administering Dilaudid to this patient.

[1] **Pyxis** is a computerized automated medication dispensing machine. The machine records the user name, patient name, medication, dose, date and time of the withdrawal. The Pyxis is integrated with hospital pharmacy inventory management systems.

PATIENT 2 (MR – V00860012405)

Date	Physician Orders	Medication Administration Record	Pyxis Record (Removal)
8/20/08	9:45 p.m.: *2mg Dilaudid* every 2 hrs PRN*		10:00 p.m.: *2mg Dilaudid*
8/21/08			12:00 a.m.: *2mg Dilaudid* 2:12 a.m.: *2mg Dilaudid* 4:12 a.m. and waste of *2 mg Dilaudid* at 4:16 a.m.; 4:30 a.m.: *4mg Dilaudid* 7:52 p.m.: *2mg Dilaudid*
		9:00 p.m.: *2mg Dilaudid* IV every 2 hrs PRN for severe pain	9:00 p.m.: *2mg Dilaudid* 9:55 p.m.: *2mg Dilaudid*
8/22/08		2:00 a.m.: *2mg Dilaudid* IV every 2 hrs PRN for severe pain 4:30 a.m.: *2mg Dilaudid* IV every 2 hrs PRN for severe pain	2:04 a.m.: *2mg Dilaudid* 4:44 p.m.: *4mg Dilaudid* and waste of *2mg Dilaudid* (same time) 6:35 a.m.: *4mg Dilaudid* and waste of *2mg Dilaudid* (same time) 7:43 p.m.: *2mg Dilaudid*

			9:59 p.m.: *2mg Dilaudid*
8/23/08			12:33 a.m.: *2mg Dilaudid* 2:25 a.m.: *2mg Dilaudid* 4:20 a.m.: *2mg Dilaudid*

*Respondent obtained new orders or change order from physician.

SUMMARY: Respondent failed to document the following withdrawals/administrations of medication on the MAR: 8/21/08: 12:00 a.m.: 2mg Dilaudid; 2:12 a.m.: 2mg Dilaudid; 4:12 a.m. (and waste of 2 mg Dilaudid at 4:16 a.m.); 4:30 a.m.: 4mg Dilaudid; 7:52 p.m.: 2mg Dilaudid. 8/22/08: 6:35 a.m.: 4mg Dilaudid (and waste of 2mg Dilaudid); 7:43 p.m.: 2mg Dilaudid; 9:59 p.m.: 2mg. 8/23/08: 12:33 a.m.: 2mg Dilaudid; 2:25 a.m.: 2mg Dilaudid; 4:20 a.m.: 2mg Dilaudid.

PATIENT 3 (MR – V00860013469)

Date	**Physician Orders**	**Medication Administration Record**	**Pyxis Record**
8/25/08	8:15 p.m.: *2mg Dilaudid* IV every 2 hrs PRN*	9:15 p.m.: *2mg Dilaudid* IV	8:58 p.m.: *2mg Dilaudid* 10:55 p.m.: *2mg Dilaudid*
8/26/08			12:29 a.m.: *2mg Dilaudid*
		1:00 a.m.: *2mg Dilaudid* IV 3:15 a.m.: *2mg Dilaudid*	1:00 a.m.: *2mg Dilaudid* 3:04 a.m.: *2mg*

		IV	*Dilaudid* 5:04 a.m.: *2mg Dilaudid* 6:59 a.m.: *2mg Dilaudid*

SUMMARY: Respondent failed to document the following withdrawals/administrations of medication on the MAR: 8/25/08: 10:55 p.m.: 2mg Dilaudid. 8/26/08: 12:29 a.m.: 2 mg Dilaudid; 5:04 a.m: 2mg Dilaudid; 6:59 a.m.: 2mg Dilaudid.

PATIENT 4

Date	Physician Orders	Medication Administration Record	Pyxis Record
7/31/08	12:45 a.m.: *1mg Dilaudid* IVP every 6 hrs PRN pain, if not received with *Vicodin*	No IV Dilaudid given	
8/2/08		No documentation that patient received Dilaudid IV	7:33 p.m.: *2mg Dilaudid* and *1mg Dilaudid* wasted (same time);
8/3/08	3:40 a.m.: 1 dose of *4mg Dilaudid* now.	No documentation that patient received *4mg Dilaudid* stat	1:25 a.m.: *2mg Dilaudid* and *1mg Dilaudid* wasted (same time). 4:23 a.m.: *4mg Dilaudid*

SUMMARY: Respondent failed to document withdrawals/administrations of medication on the MAR: 8/2/08 at 7:33 p.m.: 2mg Dilaudid. 8/3/08 at 4:23 a.m.: 4 mg Dilaudid.

18. A Pyxis usage reports at the above location indicated that the Respondent's Dilaudid withdrawals were higher as compared with other nurses overall. The usage report also showed that Respondent had "high [narcotics] activity on her shifts with her patients around midnight, which were not as prominent with the other nurses."

19. The Respondent admitted during her interview with an investigator that she failed to chart all of the controlled substance medication withdrawals and that she has difficulty with real-time documentation. Respondent also admitted that she has Attention Deficit Disorder, is "disorganized" and "gets distracted really easy."

20. Respondent's treating physicians have reported that if not properly treated, Respondent's health conditions could pose a danger to herself and others while working as a registered nurse; One physician noted that Respondent failed to comply with her treatment recommendations, which included therapy.

Methodist Hospital

21. Respondent was employed as a per diem registry nurse for Methodist Hospital during time period between 3/28/09 and 4/3/09. At all times relevant to the charges herein, Methodist hospital used a Pyxis drug dispensing system. After working approximately 4 shifts, Respondent was terminated after an investigation and review of Respondent's conduct revealed irregularities in her documentation and administration of medication as set forth below. Respondent was instructed to not return to the hospital.

PATIENT A

Date	Physician Orders	Medication	Pyxis Record

		Administration Record	
3/28/09	8:15 a.m.: *2mg Morphine* IV every 3 hrs PRN for severe pain *5mg Vicodin* by mouth every 4 hrs PRN for mod pain 8:35 a.m.: *.5mg Hydromorphone (Dilaudid)* IV every 5 hrs PRN mid-severe pain x6 11:25 a.m.: *2mg Dilaudid* IV every 4 hrs, PRN for pain; D/c IV *Morphine* may give first dose now*	10:15 a.m.: *2mg Morphine* IV every 3 hrs PRN, pain; D/c at 11:30 a.m. 11:50 a.m.: *2mg Dilaudid* IV every 4 hrs PRN, severe pain 3:47 p.m.: *2mg Dilaudid* IV every 4 hrs PRN, severe pain 5:40 p.m.: *Vicodin* tab by mouth, every 4 hrs PRN, pain	10:38 a.m.: *2mg Dilaudid* 11:50 a.m.: *2mg Dilaudid* 12:35 p.m.: Hydrocodone tab 3:47 p.m.: *2mg Dilaudid*

SUMMARY: Respondent failed to document administration of Vicodin at 12:35 a.m. and the Vicodin is unaccounted.

PATIENT B

Date	Physician Orders	Medication Administration Record	Pyxis Record
3/19/09	9:59 p.m.: *2mg Morphine*		

	Sulfate PRN, severe pain *1mg Morphine* Sulfate PRN, moderate pain		
3/23/09	8:43 a.m.: *50mg Lyrica* (Pregabalin) QAM	(No entries)	8:06 p.m.: *2mg Morphine* 9:05 p.m.: *2mg Morphine* 10:07 p.m.: *2mg Morphine*
3/24/09	8:39 a.m.: Renewal orders: *1mg Morphine* Inj/.5ml IV Push every 1 hr PRN *2mg Morphine* Inj/.5ml IV Push every 1 hr PRN	6:05 a.m.: *2mg Morphine* IV Push PRN every 1 hr	1:44 a.m.: *2mg Morphine* 6:06 a.m.: *2mg Morphine*
3/27/09	8:30 a.m. *5mg Roxanol* every 2 hrs PRN, severe pain		
3/28/09		8:30 a.m.: *2mg Morphine* IV Push every 1 hr 8:30 p.m.: *Morphine Concentrate (Roxanol)* SL PRN every 2 hrs 9:00 a.m.: *50mg Pregabalin* cap PO every morning 10:30 a.m.: *2mg Morphine* IV Push PRN every 1 hr 3:30 p.m.: *1mg Morphine* IV Push PRN every 1 hour	8:29 a.m.: *2mg Morphine* 8:35 a.m.: *50mg Pregabalin cap* (Lyrica) 10:18 a.m.: 5mg Morphine Con 10:19 a.m.: *2mg Morphine* 3:40 p.m.: *2mg Morphine* 5:34 p.m.: *2mg Morphine*

		6:40 p.m.: *2mg Morphine* IV Push PRN every 1 hr	6:52 p.m.: *2mg Morphine*

SUMMARY: Respondent failed to document withdrawals/administrations of medication on the MAR: 3/23/09: 8:06 p.m.: 2mg Morphine; 9:05 p.m.: 2mg Morphine; 10:07 p.m.: 2mg Morphine. 3/24/09: 1:44 a.m.: 2mg Morphine.

Los Robles Hospital

22. Respondent was employed as a registry nurse for Los Robles Hospital and Medical Center ("LRH") during time period between 1/27/09 to 2/6/09. At all times relevant to the charges herein, LRH used a drug dispensing system called Accudose[2]. On or around 2/6/09, Respondents contract was cancelled and Respondent was terminated after an investigation and review of Respondent's conduct with respect to two (2) patients' medical records, doctor's orders, Accudose activity reports, medication administration records ("MAR") and nursing notes revealed discrepancies in her documentation of administration of medication as set forth below. Respondent was instructed to have "no contact" with LRH.

PATIENT 1

Date	Physician Orders	Medication Administration Record	Accudose Record
1/28/08	*1-2mg Morphine Sulfate* PRN every 2 hrs for breakthrough *10/325mg Percocet* by mouth every 4 hrs PRN		
1/29/09	*80mg Oxycontin* by		

[2] **Accudose** is a decentralized medication dispensing cabinet that automates the storing, dispensing and tracking of medications in resident care areas. The system dispenses pharmaceutical medication to an individual authorized to access the system by user ID and password known only to that individual.

	mouth every 8 hrs *1mg Ativan* IV every 4 hrs PRN for nausea and vomiting *order written by Respondent		
1/30/09		1:54 a.m.: *2mg Morphine Sulfate;2mg Lorazepam*, 1mg IV every 4 hrs PRN 3:17 a.m.: *80mg Oxycodone* 5:04 a.m.: *80mg Oxycodone*	1:50 a.m.: *2mg Morphine* 1:50 a.m.: *2mg Lorazepam* (1ml *Lorazepam* waste at 1:51 a.m.) 3:08 a.m.: *80mg Oxycodone* 6:55 a.m.: *2mg Morphine Sulfate* 6:56 a.m. *2mg Lorazepam* (1ml Lorazepam waste at 6:58 a.m.) 7:04 a.m.: *2mg Morphine*
2/4/09		6:58 a.m.: *10/325 Oxycodone/ Acetaminophen* (10/325 Percocet)	1:19 a.m.: *80mg Oxycodone* 1:19 a.m.: *2mg Lorazepam* at (1ml *Lorazepam* waste at 1:21 a.m.) 6:56 a.m.: *325mg Oxycodone/APAP* 11:36 p.m.: *325mg Oxycodone/APAP* 11:37 p.m.: *2mg Lorazepam* at (.5ml Lorazepam waste at 11:40 p.m.)

2/5/09			1:28 a.m.: *80mg Oxycodone* (wasted at 1:59 a.m.) 2:03 a.m.: *80mg Oxycodone* at (to replace previous wasted pill) 9:21 p.m.*325mg Oxycodone/APAP*
2/6/09			1:18 a.m.: *80mg Oxycodone* 1:18 a.m.: *325mg Oxycodone/APAP* (returned at 2:28 a.m.) 2:29 a.m.: *325mg Oxycodone/APAP* (returned at 2:30 a.m.) 2:31 a.m.: *80mg Oxycodone* (returned at 2:31).

SUMMARY: Respondent failed to account for 4.5mg Lorazepam, three 80mg Oxycodone tablets and three 325mg Oxycodone tablets. The Lorazepam, Oxycodone and Percocet withdrawals are not all documented on the MAR. Respondent failed to document the following withdrawal/administration of medications: 1/30/09: 6:55 a.m.: 2mg Morphine Sulfate; 7:04 a.m.: 2mg Morphine. 2/4/09: 1:19 a.m.: 80mg Oxycodone; 11:36 p.m.: 325mg Oxycodone/APAP; 11:37 p.m.: 2mg Lorazepam at (.5ml Lorazepam waste at 11:40 p.m.); 2/5/09: 1:28 a.m.: 80mg Oxycodone at (wasted at 1:59 a.m.); 2:03 a.m.: 80mg Oxycodone; 9:21 p.m.325mg Oxycodone/APAP. 2/6/09: 1:18 a.m.: 80mg Oxycodone.

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PATIENT 2

Date	Physician Orders	Medication Administration Record	Accudose Record
1/29/09	9:00 p.m.: *5mg Ambien* by mouth PRN at bedtime for sleep		
2/3/09	8:50 p.m.: *2mg Dilaudid* IV every 4 hrs, PRN, for pain* 10:35 p.m.: Changed to *4mg Dilaudid* IV every 4 hrs, PRN, for pain. Give 1st dose now*	12:52 a.m.: 4mg Dilaudid every 4 hrs as needed 3:49 a.m.: 4mg Dilaudid every 4 hrs as needed 9:13 p.m.: 2mg Dilaudid every 4 hrs as needed	9:06 p.m: *2mg Dilaudid* 10:45 p.m.: *4mg Dilaudid*
2/4/09		11:07 p.m.: *5mg Zolpidem Tartrate*	12:09 a.m.: *5mg Zolpidem* 12:44 a.m.: *4mg Dilaudid* 3:35 a.m.: *4mg Dilaudid* 11:03 p.m.: *4mg Dilaudid* 11:04 p.m.: *5mg Zolpidem*
2/5/09		2:55 a.m.: *4mg Dilaudid*	2:52 a.m.: *4mg Dilaudid*

SUMMARY: Respondent failed to document administration of Ambient at 12:09 a.m. The Ambien tablet was unaccounted for.

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23. After Respondent's contract with the LRH was cancelled, Respondent was informed that she was to have no further contact with the staff or patients there. However, Respondent called the hospital despite the specific instruction she was given not to do so. *All About Staffing* was contacted and was again asked to relay the 'no communication' restriction to the Respondent.

24. When questioned by an investigator about her improper and irregular documentation, Respondent admitted "I just shouldn't be a nurse because I have ADHD and I'm really unorganized." Respondent also admitted "[r]eal time documentation is where [she] gets messed up." Respondent admitted that she is so disorganized that she "can't even pay [her] bills" and that her mother in Ohio has "taken over [her] finances." Respondent admitted that "hospitals are too busy."

25. When Respondent was asked about the unaccounted for medications that she drew from the Accudose, Respondent stated, "I didn't know how to use the machine." However, documentation signed by Respondent, indicates that Respondent did, in fact receive unit-specific orientation and in-service training of the Accudose machine.

OTHER MATTERS

Kaiser Hospital – San Diego

26. On or around the time period between June 2007 to January 2008, Respondent worked for Kaiser as a subcontractor. In the evaluation of her work performance there, Respondent was alleged to have "given Dilaudid to a patient in divided doses without obtaining a physician's order." Respondent's conduct resulted in a patient complaint and caused the patient to

"mistrust the nursing staff." Although Respondent completed the work under her contract, she was not asked to return to Kaiser.

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Continuity Care Home Nurses

27. During Respondent's time working at CCNH roughly between January and March 2010, there were several concerns relating to Respondent's conduct while working in the course and scope of her practice, which gave rise to the production of a disciplinary report and subsequent action resulting in her termination.

28. Respondent was cited at CCNH for the following actions:

a) Sending multiple text messages to a patient and making inappropriate comments about the patient based on the patient's religion.

b) Respondent also provided her mother with a patient's phone number, in violation of the clearly stated agency policy.

c) Respondent complained and spoke negatively to patients about CCNH offices.

d) Respondent discussed patients with other patients that she was seeing, also in violation of stated agency policy.

e) Respondent solicited and asked a patient for a prescription of Adderall.

f) Diverting medication from one of her patients.

29. Respondent's conduct and behavior while working in the course and scope of her duties were reported as "uncontrollable, unstable and unreliable" with respect to patients that she attended at CCNH.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Incompetence)

30. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of unprofessional conduct as defined under California Code of Regulations, title 16, sections 1443 and 1443.5, in that while working for Centinela Hospital Medical Center, Methodist Hospital, Los Robles Hospital and Methodist Hospital as a registry nurse, Respondent failed to exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse. Respondent failed to disclose and seek help concerning her personal health concerns while working as a nurse. Respondent administered Dilaudid without a physician's order. Respondent failed to properly document withdrawal and administration of medications, committing numerous charting omissions and errors. Complainant incorporates by reference paragraphs 17 – 25 as if fully set forth herein.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

31. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of gross negligence as defined under California Code of Regulations, title 16, section 1442, in that during the time period between 1/27/09 to 2/6/09 while working for Los Robles Hospital and 3/28/09 to 4/3/09 while working for Methodist Hospital as a registry nurse, Respondent demonstrated an extreme departure from the standard of care, which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse in her documentation of administered medications and in her dealings with patients, among other reasons. Complainant incorporates by reference paragraphs 21-25 as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Obtaining Controlled Substances)

32. Respondent is subject to discipline under Code section 2762, subdivision (a) on the grounds of unprofessional conduct relating to controlled substances or dangerous drugs and as defined in the relevant Health and Safety and Business and Professions code. Complainant incorporates by reference, paragraphs 17 – 25 as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Making Grossly Incorrect and Inconsistent Entries in Medical Records)

33. Respondent is subject to discipline under Code section 2762, subdivision (a) on the grounds of unprofessional conduct relating to controlled substances or dangerous drugs and when making entries into medical records and other patient records. Complainant incorporates by reference, paragraphs 17 – 25 as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 708763, issued to Jamie Marie Dvorak.

2. Ordering Jamie Marie Dvorak to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 1/26/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing

State of California
Complainant

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